Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION **BYPASS**

Abilify® (aripiprazole)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name _____

Address _____

℞

Refer for A.D.H.D. Protocol

MD _____

Signature _____

Name _____

Address _____

℞

COMPLETE PRIOR AUTHORIZATION FORMS

Dx A.D.H.D.

ICD10 F 90.9

MD _____

Signature _____

SAMPLE

Abilify® & Abilify Discmelt® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:

❑ Check if requesting **brand**

Directions for Use:

❑ Yes ❑ No **Continuation of therapy?** If "YES", answer the following:
❑ Yes ❑ No Has member been on this medication in the last 180 days?*
❑ Yes ❑ No Does the prescriber confirm that the medication has been effective in treating the member's medical condition?*

Clinical Information (required)

Your patient's pharmacy benefit program is administered by uSDoctor for certain pharmacy benefit services. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

Select the requested drug: ❑ Abilify ❑ Abilify Discmelt

Please answer the following*:

❑ Yes ❑ No Is the member **currently** on therapy?

Select the diagnosis below:

❑ Autism
❑ Bipolar disorder/bipolar mania
❑ Irritability associated with autistic disorder
❑ Major depressive disorder
❑ Schizophrenia
❑ Other diagnosis: _____

Major depressive disorder, please answer the following:

❑ Yes ❑ No Is the member **currently** taking an antidepressant, however, has had an inadequate response to antidepressant therapy?

Medication history [Abilify only]*:

❑ Yes ❑ No Does the member have a history ≥ 4 weeks of trial of the therapeutically equivalent generic? If **yes**, please document the date and duration of trial:
Date: _____ Duration of trial: _____

❑ Yes ❑ No Does the member have a documented history of intolerance to the therapeutically equivalent generic which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. take with food to minimize nausea, take prior to bedtime to manage fatigue, take in the morning to manage insomnia, eat high-fiber diet with plenty of water to minimize constipation, etc.)?

❑ Yes ❑ No Will medical records documenting the adverse effect/inadequate response to the therapeutically equivalent generic be submitted to *OptumRx*® with this form?

***Please note: Chart documentation of the above is required to be submitted along with this fax for Abilify*

Does the member have a history of failure, contraindication, or intolerance to the following?

❑ Yes ❑ No Olanzapine (generic Zyprexa)
❑ Yes ❑ No Quetiapine (generic Seroquel)
❑ Yes ❑ No Risperidone (generic Risperdal)
❑ Yes ❑ No Ziprasidone (generic Geodon)

Office use only:

Abilify® & Abilify Discmelt® Prior Authorization Request Form (Page 2 of 2)

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Quantity limit requests:
What is the quantity requested per MONTH? _____
For Abilify requests, please answer the following:
❑ Yes ❑ No Is Abilify 2mg being requested to achieve a total daily dose of 4mg?
❑ Yes ❑ No Does the member require a higher quantity for one month for dose titration?
❑ Yes ❑ No Does the member require a higher quantity to achieve a higher total daily dose?
For Abilify Discmelt requests, please answer the following:
❑ Yes ❑ No Does the member require a higher quantity for dose titration to a higher dose?
❑ Yes ❑ No Does the member require a higher quantity to achieve a higher total daily dose?
❑ Other: _____

***May not apply to all plans**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1the cocntact numbers fond on the Cover Page.

Office use only:

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

Please Note: Medical Necessity Prior Authorization may be utilized to override both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION FORM
COVER PAGE

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	

DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			

PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.

Medication/Failure Reason:

IgE:_____

ESR:_____ **CRP:**_____ **# Joints:**_____ **%BSA:**_____

Height:_____ **Weight:**_____ **BMI:**_____

HA1C:_____ **Hemoglobin:**_____ **Hematocrit:**_____ **T-Score:**_____

Dialysis:_____ **Long Term Care Facility:**_____ **Self Injecting:**_____

Stimulation test:_____/_____ **Growth velocity:**_____ **#Chemotherapy cycles/month:**_____

Mini-Mental Status Test:_____ **Baseline Free testosterone/Total testosterone:**_____/_____

HCV RNA viral load:_____ **Viral Genotype:**_____ **ALT:**_____

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	